techUK
Response to: Informing the Mental Health Strategy for England – Call for Evidence
Department of Health and Social Care
June 2026

About techUK

techUK is the trade association which brings together people, companies and organisations to realise the positive outcomes of what digital technology can do. With around 1,000 members, techUK creates a network for innovation and collaboration across business, government and stakeholders to provide a better future for people, society, the economy and the planet.

techUK members are at the forefront of digital health innovation in the UK, developing and deploying technologies that support earlier intervention, improve access to mental health services and enable more efficient, personalised and preventative care. We welcome the Government's commitment to developing a new cross-government mental health strategy and are pleased to submit evidence to inform this important work.

Executive Summary

Digital technologies and data-driven innovation offer enormous potential to transform mental health support in England – improving access, enabling earlier intervention, personalising care pathways and helping to address longstanding inequalities. techUK's response focuses on the following key themes:

- Digital and AI tools as a complement to, not a replacement for, relational care – hybrid models offer the greatest opportunity to improve outcomes at scale.
- Data as a strategic enabler – interoperable, linked datasets across health, social care, education, housing and employment can support proactive, preventative approaches.
- Neuroinclusive design – digital services must be designed from the outset to be accessible and effective for neurodivergent people, including those with autism and ADHD.
- Addressing the 'missing middle' – digital and community-based approaches can provide timely lower-intensity support for those who do not meet NHS thresholds.
- Commissioning and funding reform – outcome-based models, joint commissioning and investment in digital infrastructure are essential to deliver sustainable, integrated services.

1. Analogue to Digital

1.1 What evidence and innovative examples are there of digital and AI tools being used to achieve these outcomes? Please provide examples. (maximum 300 words)

Digital technologies and AI have significant potential to improve mental health outcomes when deployed safely, ethically and as a complement to, rather than replacement for, human-led care. Evidence from across health and care demonstrates that digital tools can improve access, reduce waiting times and support earlier intervention.

AI-enabled triage and referral management platforms, and AI-driven patient engagement tools that personalise interventions and improve adherence, can help individuals access the

most appropriate support more quickly, reducing administrative burden on clinicians. Digital patient pathways and virtual consultations embedded within existing care models, alongside digital engagement tools delivering personalised education and outcome monitoring, extend this further.

A distinct evidence base exists for digital therapeutics: software-based interventions regulated as medical devices and clinically validated through randomised controlled trials and real-world evidence, distinguishing them from the many unregulated health apps and AI chatbots where evidence of safety and efficacy is often absent. One digital therapeutic has received positive HealthTech Guidance from the National Institute for Health and Care Excellence (NICE), demonstrating clinical effectiveness and cost savings for the NHS. Several others have received positive Early Value Assessment recommendations and are developing further evidence to progress to HealthTech Guidance. This strategy has an opportunity to back proven interventions of this kind

Virtual therapy and remote support platforms have demonstrated particular value for children and young people, neurodivergent individuals, rural communities and those who may struggle to engage with traditional face-to-face services, reducing barriers associated with geography, stigma, communication preferences and service capacity.

AI also offers opportunities to identify individuals at risk of deterioration and support population-level planning through analysis of anonymised data, provided robust clinical safety, transparency, governance and human oversight remain fundamental requirements. Digital mental health services should be designed using neuroinclusive principles from the outset.

The greatest opportunity lies in combining digital innovation with relational care, creating hybrid models that improve access, enhance outcomes and enable clinicians to spend more time delivering high-value therapeutic interventions.

1.2 How can data be used more innovatively to improve mental health and wider societal outcomes? Please provide examples. (maximum 300 words)

Data has the potential to transform mental health services from reactive models of care to proactive, preventative and personalised systems that improve both individual and societal outcomes.

One significant opportunity is the use of linked, interoperable datasets across health, social care, education and voluntary sector services, using common data models and privacy-enhancing technologies to enable secure linkage and analysis. By bringing together data from multiple sources, organisations can identify populations at greater risk of poor mental health, understand unmet need and target interventions earlier.

Moving from data held only within individual professional systems to information shared across everyone involved in a person's care - patients, carers and professionals - makes care more collaborative and reduces the burden on people of repeating their health history at every contact. Structured, coded data of this kind can also inform dashboards and decision-making tools that help prioritise people at risk and identify those who may need earlier intervention.

At an individual level, patient-reported outcome measures (PROMs), digital engagement data and routine clinical information can be used to personalise care pathways and monitor progress in real time. Advanced analytics, including AI, machine learning and natural language processing, can transform clinical notes and real-world data into actionable insights, helping to predict service demand and support workforce planning.

Geography also provides a common framework through which datasets can be connected and analysed. Location intelligence can help identify areas where poor mental health outcomes coincide with poor access to services, limited public transport, lack of green space or high levels of social deprivation, and evaluate whether services are reaching the populations most in need.

To realise these benefits, investment is needed in interoperability, data quality, information governance and public trust, with safeguards to protect privacy while enabling innovation that improves mental health outcomes and wider wellbeing.

2. Sickness to Prevention

2.1 Which preventative approaches have the strongest evidence for reducing incidence or severity of mental health problems and promoting good mental health? (maximum 300 words)

The strongest evidence suggests that effective mental health prevention requires coordinated action across health, education, employment, housing and community settings, tailored across the life course and underpinned by robust health needs assessment to identify and prioritise population need.

In childhood and adolescence, school-based prevention programmes have demonstrated significant benefits, particularly those focused on emotional resilience, mental health literacy, social skills and early identification of need. Whole-school approaches that embed wellbeing into culture, leadership and teaching practice improve mental health outcomes and attainment while reducing absenteeism.

For individuals with neurodevelopmental conditions such as autism and ADHD, early assessment, tailored educational support and neuroinclusive environments are particularly important, as unmet neurodevelopmental needs increase the risk of anxiety, depression, social exclusion and poorer long-term outcomes.

Employment is another critical determinant of mental health. Evidence supports proactive workplace wellbeing programmes, flexible working arrangements, manager training and early access to occupational health support to help people remain in work and prevent deterioration.

Digital technologies can strengthen prevention across all three levels. At a primary level, digital platforms and population health analytics that integrate clinical and social determinants of health can provide accessible wellbeing resources and psychoeducation at scale. At a secondary level, risk stratification and targeted interventions, underpinned by patient registries and longitudinal datasets, can help identify individuals at higher risk and prompt timely intervention. At a tertiary level, digital monitoring and personalised care pathways help people maintain recovery and reduce relapse. Embedding these tools into real-world workflows, including schools, employers and primary care, is key to reaching people where they already are.

Community-based approaches also have strong evidence, particularly social prescribing, peer support networks and initiatives that address loneliness and social isolation, especially when integrated with health and care services and when place-based analytics are used to target them where need is greatest.

2.2 Which preventative approaches have the strongest evidence for reducing the numbers of lives lost to suicide? (maximum 300 words)

Evidence consistently demonstrates that suicide prevention is most effective when delivered through a comprehensive, multi-sector approach that combines early intervention, timely access to support, means restriction and targeted support for high-risk groups.

Active follow-up after a suicidal crisis or discharge from an emergency department or inpatient ward is one of the strongest evidence-based interventions. Simple, low-cost outreach, such as personalised contact within 48 to 72 hours of a crisis, has been shown to reduce reattempts, particularly when paired with collaborative, dynamic safety plans that set out personal triggers, coping strategies and emergency steps.

Targeted interventions for high-risk populations are also effective, including people with severe mental illness, those experiencing self-harm, neurodivergent individuals, people in contact with the criminal justice system, and those facing unemployment, homelessness or financial hardship. Evidence suggests that multilevel programmes combining several layers of intervention work better than single interventions alone.

Training frontline staff, including managers, primary care clinicians and community facilitators such as police and pharmacists, to recognise warning signs and facilitate access to support enables earlier intervention. Public awareness campaigns that reduce stigma and improve mental health literacy further encourage help-seeking.

Digital technologies can play an important complementary role. Predictive analytics using electronic health records and population data, AI-enabled risk stratification and remote monitoring tools can help identify individuals who may require additional support, while integrated, real-time data can inform more rapid responses. Data-driven approaches can also help identify geographic hotspots and populations experiencing multiple risk factors. However, these technologies should always operate within robust clinical governance frameworks and support, not replace, human decision-making.

Addressing the wider determinants of mental health, including housing insecurity, financial stress and social exclusion, is essential. Suicide prevention should be viewed as a cross-government priority requiring coordinated action across health, education, employment, housing and community sectors.

2.3 How can services better support the ‘missing middle’ - those with sustained needs (that affect their participation in community life, for example, in education or work) who may not meet the criteria for NHS mental health services? Please provide examples. (maximum 300 words)

The 'missing middle' represents a significant gap within the current mental health system. These individuals often experience persistent challenges that affect their ability to participate in education, employment and community life, yet do not meet thresholds for specialist NHS services. Many cycle between primary care, crisis services and unsupported self-management, leading to worsening outcomes and increased long-term costs.

Insomnia, for example, illustrates the scale of the problem: it affects a significant proportion of adults, meaningfully impairs functioning and increases the risk of depression, anxiety and other long-term conditions, yet rarely meets secondary-care thresholds. Patients are too often offered only dependence-forming medication or no support at all. Evidence-based digital therapeutics, validated through clinical trials and available via self-referral with no waiting list, can offer proven treatment at scale without diverting scarce clinician time from those with the most severe needs.

More broadly, addressing this gap requires stepped, person-led support that sits between self-help and specialist care - for example, co-produced care plans and secure messaging that let a young person not meeting specialist thresholds coordinate support between a school, GP and family, or allow an adult with worsening symptoms to flag concerns to a community worker before they disengage. Longitudinal care management platforms, data integration across services, and analytics to identify unmet need can help target and coordinate this support.

For people with co-occurring neurodevelopmental conditions, services should adopt neuroinclusive models that recognise the interaction between neurodiversity, mental health, education and employment outcomes. Employment and education settings also have a critical role, combining mental health support with workplace adjustments, occupational health services and supported employment programmes.

Navigation services that help individuals find appropriate local support are particularly valuable. Better use of data can help identify gaps in provision and ensure support is available where demand is greatest.

3. **What commissioning, funding and oversight or accountability arrangements (nationally and locally) best support safe and integrated mental health services that improve outcomes across mental health, participation in work, education and community life, and social functioning? Please provide examples. (maximum 300 words)**

Effective mental health services require commissioning, funding and accountability models that incentivise prevention, integration and long-term outcomes rather than activity-based delivery within organisational silos.

At a local level, ICSs should be empowered to commission jointly across health, social care, education, employment and voluntary sector services using shared outcomes frameworks, with local flexibility balanced by national oversight of safety, quality and data-sharing standards.

Nationally, funding models should place greater emphasis on prevention and early intervention, with multi-year, ring-fenced investment enabling sustainable community-based and digitally enabled services. Outcome-based commissioning, linked to measures such as wellbeing, employment retention and reduced crisis presentations, can shift focus from activity to real-world impact.

Proven digital interventions should be funded on a comparable basis to medicines. Patients have a legal right to NICE-recommended pharmaceutical treatments, but no equivalent mandate exists for digital treatments, contributing to inequitable access. Attaching central funding and local accountability to positive NICE recommendations for evidence-based digital therapeutics, subject to the same rigorous evidence and safety bar required of medicines, would help close this gap.

Digital infrastructure should be recognised as a strategic enabler, with investment in interoperable systems, shared care records, common data models and secure data sharing supporting integrated working, improved access and reduced administrative burden - alongside workforce training and expansion of nurse-led and multidisciplinary care models.

Commissioning should support trauma-informed services for groups facing additional barriers to care, and greater clarity is needed on the evolving role of ICBs and its impact on local commissioning and neighbourhood-level support.

Finally, accountability should extend beyond healthcare metrics to include recovery, quality of life, participation in education and employment, and reduced inequalities, with service users and carers involved in design and review. Aligning funding, commissioning and accountability around these outcomes will create the conditions necessary for truly integrated, person-centred mental health support.

4. Key Recommendations

Based on the evidence provided above, techUK calls on the Government to:

- Invest in hybrid digital-human care models that combine AI-enabled triage, digital self-management tools and virtual support with relational care, ensuring digital services complement rather than replace therapeutic relationships.
- Prioritise neuroinclusive design across all digital mental health services, including co-design with people with lived experience of autism, ADHD and other neurodevelopmental conditions.
- Establish a clear national framework for the safe, ethical and clinically governed use of AI and data in mental health services, including standards for transparency, oversight and interoperability.
- Enable linked, interoperable data across health, social care, education, housing and employment to support proactive, preventative and place-based approaches to mental health.
- Fund and expand community-based and digital models of support for the 'missing middle', including social prescribing, peer support, digital self-management and employment-integrated care pathways.
- Reform commissioning and funding models to prioritise prevention, early intervention and multi-year investment, with shared outcome frameworks that span health, education, employment and social care.
- Embed place-based analytics and location intelligence into population health management to identify communities at greatest risk and target resources more effectively.
- Fund evidence-based digital therapeutics on a comparable basis to medicines, attaching central funding and clear local accountability to positive NICE recommendations, subject to a rigorous evidence, regulatory and data-security bar.
- Invest in shared digital care records and common data standards that reduce duplication for patients and carers and enable earlier identification of risk across care settings.